

ARIZONA DEPARTMENT OF ECONOMIC SECURITY

Child Care Administration

EMPLOYMENT AND WAGE VERIFICATION STATEMENT

The employee below has been requested to provide the following information to the child care specialist. The information that you provide will be used for Child Care Program eligibility determination. Please provide the information in order to assist your employee. If you have any questions regarding the use of this form or the information requested, please contact the child care specialist.

EMPLOYER'S NAME AND ADDRESS

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The person named below has authorized the release of the information requested. The information provided will become part of a permanent file with access limited to representatives of DES and the employee named.

EMPLOYEE'S NAME (Last, First, M.I.)

SOC. SEC. NO.

I authorize the above-named organization or person to release the information requested.

EMPLOYEE'S SIGNATURE

EMPLOYEE INFORMATION (TO BE COMPLETED BY THE EMPLOYER)**HOURS**

NO. HOURS WORKED PER WEEK (If hours per week vary, indicate the average per week)

NO. HOURS WORKED PER DAY (If hours per day vary, indicate the range possible)

from:

to:

DAYS OF WEEK WORKED (Check all that apply)

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday
WAGES

FREQUENCY PAID (Check one)

☐ Weekly ☐ Bi-weekly (every two weeks) ☐ Semi-monthly (twice per month) ☐ Other

HOURLY WAGE

HOURLY OVERTIME WAGE (If applicable)

TIPS/COMMISSIONS RECEIVED (If applicable)

\$

\$

\$

per

NAME OF PERSON COMPLETING FORM (Type or print)

JOB TITLE

SIGNATURE OF PERSON COMPLETING FORM

PHONE NO.

DATE

IF NEWLY EMPLOYED

DATE STARTED

DATE OF FIRST CHECK

GROSS AMOUNT OF FIRST CHECK

\$

IF NO LONGER EMPLOYED

LAST DATE WORKED

DATE LAST WAGES RECEIVED

GROSS AMOUNT OF LAST WAGES RECEIVED

\$

TERMINATION DATE

TERMINATION STATUS (Check one)

☐ Laid-off☐ Quit☐ Fired☐ Other

The cost and amount of DES child care services will be based on the information provided on this wage statement. Please use the the reverse, if necessary, to clarify any of the above information provided.

DES USE ONLY

CHILD CARE SPECIALIST

PHONE NO.

CASE I.D. NO.

SITE CODE

OFFICE ADDRESS (No., Street, City, State, ZIP)

CASE NAME (Last, First, M.I.)

Equal Opportunity Employer/Program

Under the Americans with Disabilities Act (ADA), the Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. For example, this means that if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. This document is available in alternative formats by contacting: 602-542-4248.
